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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 hours of outpatient chronic pain management multidisciplinary behavioral program 10 days.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who fell down to the floor from an 18-foot elevation at work. He stated he could not get up fast enough and that it took him a long time to get up but was unable to walk very well.

On XX/XX/XX, computed tomography (CT) scan of the lumbar spine revealed suspect moderate acute compression fracture involving the superior endplate of L4 with minimal retropulsed fracture fragment or spinal canal compromise at the L3-L4 predominantly at the level involving the superior endplate of L4. Postsurgical changes were noted.

On XX/XX/XX, the patient was seen and evaluated. She was admitted on XX/XX/XX, with fever and back pain. Past medical history was significant for lumbar spine surgery on XX/XX/XX. He reported worsening back pain and swelling of the surgical wound on the back. He was brought to the hospital and started on IV antibiotics. XX reviewed the CT scan of the lumbar spine and noted compression deformity of L4 body with a 3 mm dorsal retropulsion of fracture fragments resulting in stenosis of the central canal with interval placement of bilateral pedicle screw with interlocking rod construct from L3 to L5 level. There was fluid and gas pocket scattered dorsal to the posterior element and deep to the dorsal back musculature. The patient had blood culture done on admission which was negative. He was treated with vancomycin and Zosyn. On examination, the incision on the back was around 10 cm with staples, minimal edema and minimal erythema around it. There was tenderness on the lower part. Labs were reviewed and showed WBC 6.4, hemoglobin 11, hematocrit 34, and platelets 375. BUN was 10, creatinine 1.0, AST 17, ALT 33, alkaline phosphatase was 75. Blood culture was negative. The diagnoses were subjective fever and chills on admission and lower back pain with drainage from the surgical site with CAT scan mentioned of fluid collection, concerning for an abscess. XX recommended drainage culture and ESR, CRP, and MRSA.

On XX/XX/XX, CT of the abdomen and pelvis showed inflammatory change of the left kidney. There was a 3 cm calcific density in the region of the prostate gland which may represent a prostate parenchymal calcification or a calculus within the prostatic urethra segment. L4 compression fracture deformity with L3 and L5 fixation construct was also noted.

On XX/XX/XX, x-rays of the lumbar spine revealed lateral pedicle screw fixation at the L3 and L5 level with interlocking rod construct. The hardware appeared intact without fracture. There was a fracture compression deformity of the L4 vertebral body with approximately 20% height loss. There was sclerosis of the superior endplate. There was suggestion of retropulsion but this would be better characterized with CT lumbar spine exam from XX/XX/XX. Overlying surgical staples were noted. Otherwise, lumbar spine alignment remained within normal limits.

On XX/XX/XX, the patient was evaluated for low back pain and right hip pain. He had been evaluated and was found to have compression fracture with nerve compression. He underwent surgery on XX/XX/XX. The patient stated that few days following the surgery, he developed an infection and was hospitalized for 8 days. Currently, the patient complained of moderate pain that increased with activities. He was using a walker with front wheels for ambulation. He reported frequent numbness in the right and left calf muscles more the right than the left. He also reported weakness in both legs. He had signs of anxiety, had trouble sleeping, and dreaming of falling. The current pain level was 5/10. Lower extremity strength was poor and scaled 3+/5. There were tender spinous processes of the lumbar spine over the vertebral levels of L2, L3, L5 and S1, more so on the right side than on the left. Palpation of the right hip revealed acute tenderness over the right sacroiliac joint and lateral side of the right hip. The following orthopedic tests were positive: Kemp's test caused pain, straight leg raising (SLR) on the left at 25 degrees, Well leg raising on the right at 29 degrees, Hibb's test right hip, and iliac compression right SI joint. The lumbar spine ROM was flexion 22 degrees with pain, extension 8 degrees, left lateral flexion 18 degrees and right lateral flexion 22 degrees. XX diagnosed postoperative lumbar spine, compression fracture, sprain/strain lumbar spine, sprain/strain right SI joint, sprain/strain right hip joint, low back pain, lumbar spine nerve root compression, and lumbar spine myospasms. XX prescribed tramadol 50 mg and naproxen 500 mg; ordered physical therapy (PT) and electrodiagnostic studies. He was placed off work.

On XX/XX/XX, the patient was evaluated. He was evaluated due to symptoms of posttraumatic stress disorder (PTSD). XX diagnosed PTSD (acute stage), post lumbar surgery, compression fracture, lumbar sprain/strain, right hip joint sprain/strain, low back pain, lumbar spine nerve root compression, lumbar spine myospasms, and right SI joint sprain/strain. His current global assessment of functioning (GAF) was 55. XX recommended six individual psychotherapy sessions once a week.

From XX/XX/XX, -XX/XX/XX, the patient attended six individual therapy sessions.

On XX/XX/XX, the patient followed up. He was improving as expected. XX recommended 12 additional sessions of PT. Proposed modalities included therapeutic exercise and soft tissue mobilization.

On XX/XX/XX, the patient had a mental health assessment completed. He had attended six individual therapy sessions. The patient rated his pain level at 5-6/10 on McGill Pain Questionnaire. His Beck Depression Inventory (BDI) score was 27, and Beck Anxiety Inventory (BAI) was 30. His diagnosis was acute PTSD. The other diagnoses included post lumbar surgery, compression fracture, lumbar sprain/strain, right hip joint sprain/strain, low back pain, lumbar spine nerve root compression, lumbar spine myospasms, and right SI joint sprain/strain. The current GAF was 60. It was noted that the patient had developed psychological barriers that required a multidisciplinary approach to have a satisfactory outcome. He exhibited pain behaviors, functional limitations, and mental/emotional dysfunctions which were disruptive to his activities of daily living (ADLs) due to the loss of physical limitations. He had not responded to primary, secondary, and/or tertiary levels of care of outpatient treatment including PT and medications. It was felt that he would benefit from a structured intensive multidisciplinary individualized treatment. XX recommended outpatient chronic pain management multidisciplinary behavioral program for 10 days five times a week for two weeks.

On XX/XX/XX, an initial functional capacity evaluation was completed. The patient qualified at Sedentary physical demand level (PDL) versus the heavy PDL required for his job. He was able to sit 10 minutes, walk 10 minutes, and stand 10 minutes. He had aggravation of pain to the lumbar spine and right hip regions with weakness to lower extremities on carrying, lifting, walking, standing, kneeling, balancing, squatting, and handling during gross mobility testing. Participation in chronic pain program was requested.

On XX/XX/XX, XX completed a Designated Doctor Evaluation (DDE). The diagnoses were compression fracture of L4 (20% loss of height) and status post L3-L5 instrumentation and fusion. XX opined that the patient was not at maximum medical improvement (MMI) at this time but was expected to on about XX/XX/XX. The extent of injury included the vertebral compression fracture at L3-L4, L4-L5 and L5-S1, poor sleep, PTSD, and anxiety.

On XX/XX/XX, XX performed a utilization review and denied the request for multidisciplinary chronic pain management (80 hours) five times a week for 10 days with the following rationale: *"the patient is a male who had a slip and fall injury on XX/XX/XX from a height of 18 feet. He was diagnosed with post traumatic stress disorder. A request for 10 days of Multidisciplinary Chronic Pain Management at 80 hours for 5 times per week was made. He has received treatment in the form of medication, surgery, PT, chiropractic therapy, TENS, and psychotherapy. He underwent spinal instrumentation with pedicle and screws at L3-L5 on XX/XX/XX for a lumbar compression fracture at L4. FCE on the same date revealed current patient functioning at Sedentary PDL for a job requirement of Heavy PDL. Psychological evaluation on XX/XX/XX revealed scores of 5-6/10 for McGill Pain Questionnaire, 27 (moderate depression) on BDI, and 30 (moderate anxiety) on BAI. He took tramadol and naproxen for pain. He*

was recommended to attend an outpatient chronic pain management program to manage his pain levels. It was stated that the patient demonstrated improvement after six sessions of psychotherapy. However, there was no documentation that other previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. In addition, negative predictors of success were not identified and addressed in the records. As such, medical necessity is not established for the requested service."

On XX/XX/XX, XX requested a reconsideration for multidisciplinary chronic pain management program five times a week for 10 days. The patient had undergone primary and secondary levels of treatments. Although, he had undergone conservative and secondary treatment in the past such as emergency hospital care, X-rays, MRI, lumbar surgery x1, post-op therapy, anti-inflammatory medications, pain medications, individual sessions (PTSD) and he continued to experience pain and limited range of motion to the lumbar and also as indicated in medical notes. Therefore, the recommended services would continue to address the physical and psychological deficits under a supervised setting. He displayed a positive attitude and motivation in improving his current situation and wanting to return to work. The goals were to improve range of motion, increase strength, stamina, go from walker to walking on his own, decreased pain levels, wean off all pain medications and for the patient to be performing his at a medium/heavy PDL.

On XX/XX/XX, XX completed a reconsideration review and upheld the denial. Rationale: "*This is a case of a employee who sustained a work-related injury on XX/XX/XX after he slipped from a roof and fell 18 feet down to the floor. The patient was diagnosed with postoperative lumbar spine surgery, compression fracture, sprain and strain of the lumbar spine, sacroiliac joint and right hip joint, low back pain, lumbar spine nerve root compression, and lumbar spine myospasms. On Mental Health Assessment dated XX/XX/XX, the patient had a typical pain level of 5-6/10. Beck Depression Inventory (BDI) scored 27 indicative of moderate depression levels, Beck Anxiety Inventory scored 30 indicative of moderate anxiety levels. With the patient's individual therapy sessions, he began to slowly realize that even if he does not get 100% better, he could still work, if he finds a job that he is physically, mentally, and emotionally able to do. The patient exhibited pain behaviors, functional limitations, and mental and emotional dysfunctions which were disruptive to his activities of daily living. According to the Initial Functional Capacity Evaluation by XX dated XX/XX/XX, the patient complained of pain to the lumbar spine and right hip region with restricted range of motion and weakness to the lower extremities. His perceived limitations included walking, standing, sitting, carrying, lifting, kneeling, climbing, balancing, squatting, bending, pushing, and pulling. Grip strength was suggestive of maximal effort. Lumbar spine had 41% to 61% deficits. The patient was currently performing at a sedentary PDL while his required PDL was heavy. On Ransford pain drawing, the patient scored 1 point. On McGill Pain Questionnaire, the patient had a pain rating index (PRI) of 23, and NWC of 10. The patient had an Owestry low back pain disability score of 46%. Million visual analog scale had a total score of 91. The patient had a forward slouched posture on sitting. On gait analysis, the patient had a prolonged weight bearing on the left stance phase. ROM of the spine showed lumbar flexion of 35 degrees, lumbar extension and bilateral lateral flexion of 10 degrees. Maximum safe pushing and pulling force was 20 pounds. Maximum safe lifting weight was 10 pounds. MRI (undated) documented a compression fracture with nerve compression injury. The patient was taking tramadol and naproxen. Prior treatments included chiropractic care, physical therapy, use of transcutaneous electrical nerve stimulation (TENS) unit, and medications. The patient had six individual therapy sessions. The patient underwent lumbar spine surgery on XX/XX/XX. The current request is for multidisciplinary chronic pain management for 80 hours, 5 times per week, 8 hours per day, equal to 10 days. Guidelines suggest that multidisciplinary pain programs are recommended when previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Medical records failed to indicate if there was a failure from the conservative treatments used by the patient. The patient's previous individual therapy sessions were also already able to address some of the patient's psychosocial and psychological barriers. Although the patient still had some deficits, negative predictors had not been addressed. As such, the request does not meet guidelines recommended."*

On XX/XX/XX, XX wrote a Letter of Medical Necessity. He stated that the patient participated in a functional capacity evaluation dated XX/XX/XX, and a Mental Health Assessment on XX/XX/XX. He was re-evaluated, tested by licensed professionals and was recommended to participate in a Multidisciplinary Chronic Pain Program to address his psychological barriers (PTSD) and physical deficits that were preventing him from returning back to gainful employment. As indicated in the Behavioral Assessment dated XX/XX/XX, he continued to display symptoms of PTSD, but reported these symptoms had lessened and his BDI score was now at 27 and Beck Anxiety Inventory score 30. He endorsed having pain levels of 5-6 especially to his lumbar with limited range of motion. He was using a wheel chair and now walking with the aid of a walker. Thus making him an ideal candidate for participation in a return to work program (i.e. functional restoration programs). He has participated in conservative and secondary levels of care and he has made positive progress in his recovery from this work related injury. He had lumbar spine surgery and was no longer a candidate for further surgery. He does not meet criteria for pain management injections and the patient had no tenderness over the hardware to indicate a symptomatic spinal fixation to justify the request for a hardware block. Therefore, he did not meet criteria for pain management injections. He meets the ODG criteria for a Multidisciplinary Chronic Pain Program and he had made positive improvement but continued to have some continued physical deficits reconditioning and psychological barriers that were preventing him from returning back to work. The patient's FCE indicates that his job places him in a heavy job classification as determined by NIOSH standards he is functioning at a sedentary PDL. He was then evaluated by XX, as a request by DD physician XX, lll. She diagnosed the patient with PTSD and Somatic Symptom Disorder with Predominant Pain due to his pain. Therefore, he does meet the ODG for participation in a multidisciplinary chronic pain program where his physical and psychological deficits can be addressed as he proceeds to return to work. He had participated in lower levels of treatment such as emergency hospital care, x-rays, MRI, lumbar surgery x1, postop therapy, chiropractic services, individual sessions to address his symptoms of PTSD, poor sleep and chronic pain, and pain medications. He was nonambulatory and was in a wheel chair and now he was walking with the aid of a walker. He had made significant improvement and continued to demonstrate positive motivation and wanting to improve his current condition. A treatment plan was submitted and did address the return to work goals recommended while he participated in the

multidisciplinary chronic pain program. He did present with physical limitations and high pain behaviors, PTSD, somatic symptom disorder, severe predominate pain per OD Physician XX, which were limiting him from returning back to work. A reconsideration for the 80 hours of Multidisciplinary Behavioral Chronic Pain Program were requested and it was sent to peer to peer physician, XX. XX was not given the opportunity to conduct the peer review with XX as the call went to XX, psychiatrist. She informed the physician reviewer that she had not made the request only a psychiatric evaluation XX/XX/XX, as was recommended by XX. She also agreed that the patient did suffer from PTSD and somatic symptom disorder, severe with predominate pain. XX denied the reconsideration as he indicated medically necessity was not established.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

As stated by prior reviews, there is no evidence supporting that other conservative measures have failed. In addition, one of the goals is to reduce the need for medications and this individual is on minimal at the present time. He has also participated in a plethora of modalities that would be duplicated in a chronic pain program. In conclusion, evidence does not support the need for a multidisciplinary chronic pain program and the decision should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**